

**First Health Services of Montana**  
**MHSP EMERGENCY ELIGIBILITY ASSESSMENT FORM**

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First Health Services of Montana

To transmit request information:

FAX: 1-800-639-8982

PHONE: 1-800-770-3084

Mail: 4300 Cox Road

Glen Allen, VA 23060

Please print or type:

<b>PROVIDER INFORMATION</b>		
Name of Provider:		
Telephone Number:	Fax Number:	
Medicaid Provider Number:		
Clinician/Therapist:		
<b>PATIENT INFORMATION</b>		
Patient Name:		
Marital Status: single • married • separated • divorced •		
DOB: / /	Gender: M • F •	
Address:		
City:	State:	Zip Code:
Medicaid Eligible: Yes • No • SSN:		
MHSP Eligible: Yes • No •		
<b>RESPONSIBLE PARTY INFORMATION (if other than patient)</b>		
Name:		
Address:		
City:	State:	Zip Code:
Telephone Number:		
Relationship to patient: self • parents • government agency • other relative •		
<b>CLINICAL INFORMATION</b>		
Date/Dates of Treatment:		
Clinical indicators that substantiate emergent contact:		
Check any of the following that apply: Suicidal • Homicidal • At risk to self or others • Face to Face Intervention • Telephone Intervention •		
Disposition of patient:		
Outcome of the assessment:		

**IF ADMITTED TO ADULT CRISIS STABILIZATION-FACILITY MUST COMPLETE AN ADULT CRISIS STABILIZATION REQUEST FORM**

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For First Health's Use Only:

11/00

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Processing may be delayed if information submitted is illegible or incomplete



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APPROVED: \_\_\_\_\_

DENIED: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewer Signature: \_\_\_\_\_